DEPARTMENT OF HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID AND MEDICAL ASSISTANCE

Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

FINAL

ORDER

70000 Certification and Regulation of Medicaid Managed Care Organizations

NATURE OF THE PROCEEDINGS:

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance (DMMA) initiated proceedings to amend the Division of Social Services Manual (DSSM) regarding fiscal solvency standards for managed care organizations (MCOs) serving State Medicaid clients, specifically, *Certification and Regulation of Medicaid Managed Care Organizations*. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Delaware Code** Section 10114 and its authority as prescribed by 31 **Delaware Code** Section 512.

The Department published its notice of proposed regulation changes pursuant to 29 **Delaware Code** Section 10115 in the January 2015 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by January 31, 2015 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

SUMMARY OF PROPOSAL

The purpose of this notice is to advise the public that Delaware Health and Social Services/Division of Medicaid and Medical Assistance is proposing to amend the Division of Social Services Manual (DSSM) regarding fiscal solvency standards for managed care organizations (MCOs) serving State Medicaid clients, specifically, *Certification and Regulation of Medicaid Managed Care Organizations*.

Statutory Authority and Other References

- Section 1902(a)(4) of the Social Security Act, *State Plan for Medical Assistance, Methods of Administration*
- Section 1903(m), *Medicaid Managed Care Organization*
- 29 Del. C. §7931, *Division of Medicaid and Medical Assistance*
- 42 CFR § ~~**[483.1]**~~ **[438.1]**, Managed Care, Basis and scope
- 42 CFR § ~~**[483.116]**~~ **[438.116]**, Solvency standards
- State Medicaid Director Letter, December 30, 1997, An array of provisions including *beneficiary protections, solvency standards and contract administration*

Background

Medicaid Managed Care

Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.

Managed Care in Delaware

Delaware has been operating a mandatory managed care program since 1996 when it implemented Diamond State Health Plan (DSHP), which covers acute, primary, and behavioral health care services for low-income children, families, and adults; children and adults with disabilities; and foster care children. In April 2012, the state expanded managed care to additional populations and added long term supports and services (LTSS) to the benefit package with the implementation of the DSHP-Plus program. This program enrolls dual eligible beneficiaries, individuals enrolled in the Elderly and Disabled and AIDS home and community-based service (HCBS) waivers, and nursing facility residents on a mandatory basis and provides LTSS and acute, primary, and behavioral health care services to eligible individuals. DSHP and DSHP-Plus cover a limited number of outpatient and inpatient behavioral health and substance abuse services and any services in excess of the limits on visits are provided as a fee-for-service wraparound.

Solvency Standards

With respect to solvency standards imposed on the MCO by the State, federal law indicates that MCOs should meet

solvency standards that the State establishes for its private MCOs or should be licensed by the State as risk-bearing entities. In accordance with above-referenced federal and state regulations:

1. States are authorized to administer Medicaid through Medicaid managed care organizations (each an "MMCO").
2. An MMCO shall provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the debts if the MMCO becomes insolvent.
3. An MMCO, in order to make the required showing under Section 438.116(a), must either meet state solvency requirements for a private health maintenance organization, or be licensed or certified by the State as a risk bearing entity.

Summary of Proposal

Purpose

The purpose of these regulations is to create standards of fiscal solvency. These regulations establish the standards by which Delaware Health and Social Services/Division of Medicaid and Medical Assistance (DHSS/DMMA) will evaluate and, where appropriate, certify insurers as MMCOs.

Summary of Proposal

This administrative regulation establishes the operational and related requirements and policies of managed care organization serving State Medicaid clients. DHSS/DMMA proposes new DSSM 70000 concerning the solvency standards required by managed care organizations participating in the Delaware Medical Assistance Program (DMAP). This new section is proposed as, *Certification and Regulation of Medicaid Managed Care Organizations* and is consistent with federal regulations.

Public Notice

In accordance with public notice requirements established at Section 1902(a)(13)(A) of the Social Security Act, and Title 29, Chapter 101 of the Delaware Code, Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) is seeking public comment on the proposed regulations.

Fiscal Impact Statement

There is no fiscal impact.

SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGES

The Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following observations and recommendations summarized below. The Division of Medicaid and Medical Assistance (DMMA) has considered each comment and responds as follows.

GACEC and SCPD

As background, DMMA contracts with MCOs to administer the Diamond State Health Plan and Diamond State Health Plan Plus programs. Federal regulation 42 C.F.R. §438.116 (attached) requires MCOs to <u>either</u> meet state solvency standards for private health maintenance organizations <u>or</u> be licensed or certified by the state as a risk-bearing entity. Delaware DMMA is adopting the second option, i.e., it will certify MCOs which meet certain standards contained in the proposed regulation.

Agency Response Note: This characterization is correct. Thank you for your thoughtful comments on the proposed standards for the regulation of the financial solvency of MCOs.

GACEC and SCPD have the following observations:

First, on p. 504, the references to 42 C.F.R. §483.1 and 42 C.F.R. §483.116 are incorrect. The correct citations are 42 C.F.R. §438.1 and 42 C.F.R. §438.116 respectively.

Agency Response: This edit has been made.

Second, §3.1.2 requires an MCO to demonstrate "net equity in excess of $[10] million." At a minimum, the brackets should be deleted. On a substantive level, the Councils questions whether net equity of $10 million is sufficient. Delaware's Medicaid population has grown to approximately 230,000 individuals. <u>See</u> DHSS Secretary's FY16 budget presentation to OMB (November 20, 2014), available at <u>http://www.dhss.delaware.gov/dhss/index.html</u>. Most of Delaware's Medicaid population is served by two MCOs (Highmark; United Healthcare). Assuming equal enrollment, each MCO would serve 115,000 individuals and have approximately $86 in equity for each participant. Some of the $10 million in equity could be in fixed or non-liquid assets out-of state or out of the country. We recognize that the managed care system is intended to not tap equity, i.e., monthly State capitation payments (§5.2) should ideally cover MCO outlays. Moreover, DMMA enjoys the protection of a performance bond equal to one month's capitation payment. In reality, an MCO could suffer huge losses if an epidemic or natural disaster resulted in unanticipated health costs. An MCO with only $10 million in net equity may be unable to absorb such costs.

Agency Response: The recommended deletion of the brackets has been made. DMMA believes that the $10 million in net equity, coupled with the required performance bond and certification of financial stability, is adequate.

Third, §5.0 may merit further review to ensure consistency. On the one hand, an MCO is required to submit a performance bond equal to the projected first month's capitation payment "up front". See §§5.1 and 5.2. On the other hand, §5.4 requires MCO supplementation of the bond "if the performance bond falls below 90% of the first month's capitation in any month". Literally, this could never occur since the performance bond based on 100% of the first month's capitation amount was already submitted to DMMA up front. If DMMA intends that the MCO increase the bond based on later increases in monthly capitation amounts, the regulation should be reworded.

Agency Response: DMMA has made changes to the regulation based on this comment. First, it has stricken the words "and submit" since the MCOs will maintain the performance bond, and report that to DMMA. The performance bond is only required to cover startup costs for the first 12 months of the MCO contracts. Thereafter, DMMA gauges and assesses the financial stability of the MCO through record review and mandatory notice requirements contained in the MCO contracts.

Fourth, §9.1 contemplates MCO maintenance of a system for tracking incurred but unreported costs and unpaid claims by category (e.g. hospital; nursing facility). The MCO is expected to review its system annually and DHSS can prompt adjustments. DMMA may wish to consider requiring a 6-month report of data under this section. If a year passes, and the system/methodology has resulted in grossly inadequate reservation of funds, it may be too late to intervene in the face of huge unpaid bills.

Agency Response: DMMA believes that the regulation as written, e.g. annual reviews, not biannual reviews, of the methodology for estimating and tracking IBNR, is appropriate. The MCOs are required to report actual IBNR to DMMA quarterly. DMMA believes that this mechanism addresses the concerns raised by this comment.

Fifth, it's unclear when the performance bond required by §5.0 lapses. Obviously, an MCO which terminates its participation as an MCO will still have to cover bills incurred during the contract period. It is possible that the DMMA-MCO contract addresses the duration of the performance bond. If it does not, the regulation could be revised to include some standards.

Agency Response: The DMMA-MCO contract does indeed authorize collection of unpaid monies from the performance bond to collect in the event of an MCO default.

GACEC

Sixth, Council would also recommend that GAAP and STAT be spelled out in sections 3.1.2 and 4.1.1.

Agency Response: This edit has been made.

FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the January 2015 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Division of Social Services Manual (DSSM) regarding fiscal solvency standards for managed care organizations (MCOs) serving State Medicaid clients, specifically, *Certification and Regulation of Medicaid Managed Care Organizations*, is adopted and shall be final effective March 10, 2015.

Rita M. Landgraf, Secretary, DHSS

DMMA FINAL ORDER REGULATION #15-05
NEW

70000 Certification and Regulation of Medicaid Managed Care Organizations

1. Authority and Purpose

1.1 This regulation is promulgated pursuant to Section 7931(d) of Title 29, Delaware Code.

1.2 Pursuant to Section 1902(a)(4) of Title XIX of the Social Security Act (42 U.S.C. §1396a(4)) and 42 C.F.R. §438.1 *et. seq*., the states are authorized to administer Medicaid through Medicaid managed care organizations (each an "MMCO").

1.3 Pursuant to 42 C.F.R. §438.116(a), an MMCO shall provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for its debts if the MMCO becomes insolvent.

1.4 Pursuant to 42 C.F.R. §438.116(b)(1), in order to make the required showing under Section 438.116(a), an MMCO must either meet state solvency requirements for a private health maintenance organization, or be licensed or certified by the State as a risk bearing entity.

1.5 Pursuant to 18 **Del.C.** §7931(c), the Division of Medicaid and Medical Assistance ("DMMA"), which is under the direction and control of the Secretary of the Department of Health and Social Services ("DHSS"), is responsible for the performance of all of the powers, duties, and functions specifically related to Medicaid, which includes certification of MMCOs.

1.6 The purpose of these regulations is to set forth standards for the certification of MMCOs as risk bearing entities.

2. Formation and Existence

2.1 Each MMCO seeking certification from DHSS shall demonstrate to the satisfaction of DHSS that:

2.1.1 The MMCO is duly formed and validly existing under the laws of the State of Delaware.

2.1.2 The MMCO has the necessary corporate or company power to enter into and perform its obligations under the State Medicaid Managed Care Contract (the "Contract").

2.1.3 The MMCO has taken all necessary corporate or company action to authorize the execution, delivery and performance of the Contract.

2.1.4 The execution and delivery of the Contract will not, and the performance of the MMCO's obligations under the Contract will not, result in a violation of any provision of the MMCO's certificate of incorporation, bylaws or other governing instrument or document.

2.1.5 An opinion of Delaware counsel to the MMCO will be *prima facie* evidence that the criteria in this Section 2 are satisfied.

3. Experience and Net Worth

3.1 Either the MMCO, or a parent company or person affiliated with the MMCO, shall demonstrate, to the satisfaction of DHSS, the following:

3.1.1 Five years' experience writing or administering health insurance benefits or administering health plans, or both.

3.1.2 Audited financial statements for the most recent calendar or fiscal year demonstrating, on a consolidated basis, **[~~GAAP~~ generally accepted accounting principles]** net equity in excess of **[~~$[10]~~ $10]** million.

4. Identification of Accountant, Auditor and Actuary

4.1 Each MMCO seeking certification shall identify:

4.1.1 The person or persons responsible for preparing the MMCO's financial statements in U.S. **[~~GAAP and/or STAT~~ generally accepted accounting principles]** format and for preparing any financial reporting required under the Contract. Such person shall have accounting or finance training and experience, and shall have experience in the preparation of financial statements for health plans.

4.1.2 The independent auditor that the MMCO proposes to engage for the purpose of auditing its financial books and records. Such independent auditor shall be a certified public accountant, or employ same, and shall be a member in good standing with the American Institute of Certified Public Accountants. The independent auditor shall have experience auditing health plans.

4.1.3 The actuary it proposes to use for the purpose of certifying loss reserves. Such actuary shall be a member of the American Academy of Actuaries in good standing and shall demonstrate experience in the setting and/or certification of loss reserves for health plans.

5. Performance Bond

5.1 Prior to certification, the MMCO shall obtain **[~~and submit to DHSS~~]** a performance bond from a surety licensed to write surety business in Delaware and rated A- (Excellent) or better by A.M. Best and Company. The performance bond shall be restricted to the Contract.

5.2 The performance bond shall identify the Delaware Department of Health and Social Services as obligee and shall be in the amount of the projected first month's capitation payment under the Contract, as agreed to by the MMCO and DHSS.

5.3 The MMCO shall secure and maintain the performance bond in the amount of 100% of the first month of capitation payment for each of the first 12 months after the Start Date of Operations (as defined in the Contract).

5.4 If the performance bond falls below 90% of the first month's capitation in any month, the MMCO has 30 calendar days to comply with the requirements of this Section and provide proof of the increased bond amount.

5.5 The terms of the performance bond shall be such as to allow for adjustment in the amount of the penal sum payable thereon in accordance with the performance bond requirements of the Contract.

6. Initial Capitalization and Solvency

6.1 Each MMCO seeking certification shall provide DHSS with a description of the MMCO's capitalization and the manner in which it proposes to ensure solvency during the term of the Contract. This description may include one or a combination of some or all of the following:

6.1.1 A minimum level of paid-in capital and surplus as established by DHSS.

6.1.2 Reinsurance or insurance transactions.

6.1.3 Derivative instruments.

6.1.4 Guaranties from parent or affiliated entities.

6.1.5 Any other method determined by DHSS to provide adequate solvency safeguards.

6.2 Prior to certification, the MMCO shall provide DHSS with bank confirmations for all funds it identifies, or plans to identify, as assets on its financial statements.

6.3 Each MMCO seeking certification shall establish an investment policy for the investment of its assets. Such investment policy shall not deviate from the following:

6.3.1 Investments in any one entity shall not exceed 10% of the MMCOs' assets unless:

6.3.1.1 Such investments are the voting stock or other interests in a subsidiary.

6.3.1.2 Such investments are general obligations of the United States or of a state.

6.3.1.3 Such investments are issued, assumed or guaranteed by an agency of the United States government, or in which the United States government is a participant.

6.3.2 Investments in medium or lower grade corporate obligations shall comply with the requirements of 18 **Del.C.** Ch. 13.

6.3.3 Investments in real estate mortgages and mortgage pools are permitted provided that such investments comply with the requirements of 18 **Del.C.** §1323.

6.3.4 Investments in the MMCO's own capital stock or other equity interests are prohibited.

6.3.5 Notes or other evidence of indebtedness of any director, officer, employee or controlling shareholder of the MMCO are prohibited.

7. Certification.

7.1 If upon completion of its application, DHSS finds that the MMCO has met the requirements therefor under this regulation; DHSS shall issue to the MMCO a proper certificate confirming that the MMCO has been certified as a risk bearing entity for purposes of the Delaware Medicaid program. If DHSS finds that the MMCO has not met the requirements for certification under this regulation, DHSS shall issue an order refusing such certification.

7.2 DHSS's certification of an MMCO as a risk bearing entity shall be limited to the MMCO's business related to the Delaware Medicaid program and shall not authorize the MMCO to conduct business that would otherwise require licensure under Title 18 of the Delaware Code.

7.3 Although issued and delivered to the MMCO, the certificate issued pursuant to Section 7.1 of this regulation at all times shall be property of the State. Upon expiration, suspension or termination thereof, the MMCO shall promptly deliver the certificate to DHSS.

8. Financial Stability

8.1 The MMCO shall be responsible for its sound financial management in accordance with applicable professional standards. The MMCO shall:

8.1.1 Present to DHSS any information and records deemed necessary to determine its financial condition. The response to requests for information and records shall be delivered to DHSS, at no cost to DHSS, in a reasonable time from the date of the request or as specified therein.

8.1.2 Immediately notify DHSS when the MMCO has reason to consider insolvency or otherwise has reason to believe it or any of its subcontractors is other than financially sound and stable, or when financial difficulties are significant enough for the Chief Executive Officer or Chief Financial Officer to notify the MMCO's governing body of the potential for insolvency, and

8.1.3 Maintain a uniform accounting system that adheres to generally accepted accounting principles for charging and allocating to all funding resources the MMCO's costs incurred hereunder including, but not limited to, the American Institute of Certified Public Accountants Statement of Position 89-5 "Financial Accounting and Reporting by Providers of Prepaid Health Care Services."

8.2 The MMCO shall contract with an independent licensed certified public accountant to conduct an annual financial audit of the MMCO, including but not limited to the financial transactions made under the Contract.

8.3 The MMCO shall notify DHSS within 10 calendar days if its contract with an independent auditor or actuary has changed or been terminated. The notification shall include the date of and reason for the change or termination. If the change or termination occurred as a result of a disagreement or dispute, the notification shall include the nature of the disagreement or dispute. In addition, the notification shall include the name of the replacement auditor or actuary, if any.

9. Reserved Funds For Incurred But Not Reported Costs And Received But Unpaid Claims

9.1 The MMCO shall establish and maintain an actuarially sound process for estimating and tracking incurred but not reported costs and received but unpaid claims. The MMCO shall reserve funds for each major category of service (e.g., hospital inpatient, physician, nursing facility) to cover both incurred but not reported and reported but unpaid claims. The MMCO shall conduct reviews, at least annually, to assess its reserving methodology and make adjustments deemed by DHSS to be necessary to the methodology.

10. Inspection and Audit of Financial Records

10.1 The MMCO shall meet all federal and state requirements with respect to inspection and auditing of financial records. The MMCO shall cooperate with DHSS or its authorized representative and provide all financial records, including but not limited to records of its subcontractors, related party agreements, and provider participation agreements as specified by DHSS so that DHSS or its authorized representative or the federal Department of Health and Human Services or its authorized representative may inspect and audit the MMCO's financial records at least annually or at DHSS's discretion.

10.2 The MMCO shall submit financial reports as described in the Financial Reporting Guide, which is incorporated by reference into this regulation.

11. Decertification

11.1 The MMCO shall at all times comply with the requirements set forth in the Contract. DHSS may immediately revoke the MCCO's certification upon termination of the Contract in accordance with its terms or as a result of a breach thereof by the MMCO, or upon the determination of DHSS that:

11.1.1 the MMCO has become financially unsound to the point of threatening the ability of DHSS to obtain the services provided for under the Contract,

11.1.2 the MMCO ceases to conduct business in the normal course,

11.1.3 the MMCO makes a general assignment for the benefit of creditors, or

11.1.4 the MMCO suffers or permits the appointment of a receiver for its business or its assets.

11.2 In the event of such decertification, DHSS shall notify the MMCO of the proposed decertification in accordance with 29 **Del.C.** §§10122 and 10131. If the MMCO requests a hearing on the proposed decertification, DHSS shall appoint a hearing officer to preside over the hearing.

11.3 Hearing procedures

11.3.1 At any hearing on the proposed decertification, the parties shall have the right to appear in person or be represented by counsel, or both. The parties shall have the right to produce evidence and witnesses on their behalf and to cross examine witnesses.

11.3.2 No fewer than 10 days prior to the date set for any hearing on the proposed decertification, the parties shall submit to the hearing officer a list of the witnesses they intend to call at the hearing. Witnesses not listed shall be permitted to testify only upon a showing of reasonable cause for such omission.

11.3.3 The hearing officer may administer oaths, take testimony, hear proofs and receive exhibits into evidence at any hearing. All testimony at any hearing shall be under oath.

11.3.4 Strict rules of evidence shall not apply. All evidence having probative value commonly accepted by reasonably prudent people in the conduct of their affairs shall be admitted.

11.3.5 An attorney representing a party in a hearing or matter before the hearing officer shall notify the hearing officer of the representation in writing as soon as practicable.

11.3.6 Requests for postponements of any matter scheduled before the hearing officer shall be submitted to the hearing officer in writing no fewer than three (3) days before the date scheduled for the hearing. Absent a

showing of exceptional hardship, there shall be a maximum of one postponement allowed to each party to any hearing.

11.3.7 If the MMCO fails to appear at the decertification hearing after receiving the notice required by 29 **Del.C.** §10122 and 10131, the hearing officer may proceed to hear and determine the validity of the proposed decertification.

11.3.8 The hearing officer shall render a decision based solely on the evidence admitted at the hearing.

11.4 In the event of decertification, the MMCO shall be paid for any outstanding monies due less any assessed sanctions in accordance with the Contract.